Revised 2/95

Louis LaTorre,Director
Social Services

BOARD OF COUNTY COMMISSIONERS
AGENDA ITEM SUMMARY

Meeting Date: 8/18-8/19/04 Division: Community Services

Bulk Item: Yes X No ___ Department: Social Services

AGENDA ITEM WORDING: Approval for Monroe County to continue to participate in a Provider Agreement with the Florida Medicaid Program for Assistive Care Services for residents of Bayshore Manor.

ITEM BACKGROUND: Bayshore Manor currently houses two (2) residents who receive Assistive Care Services through Florida Medicaid. We need to continue participation in this program so residents benefits continue.

PREVIOUS RELEVANT BOCC ACTION: At the November 21, 2000 Board of County Commissioners meeting, the Board granted approval and authorized execution of an Institutional Medicaid Provider Agreement between Monroe County and the Florida Medicaid Program for Assistive Care Services for residents of Bayshore Manor.

CONTRACT/AGREEMENT CHANGES: N/A

STAFF RECOMMENDATIONS: Approval

TOTAL COST: $ N/A BUDGETED: Yes X No ___

COST TO COUNTY: N/A

REVENUE PRODUCING: Yes X No ___ Amount per Month $556.80

APPROVED BY: County Atty. ___ OMB/Purchasing ___ Risk Management ___

DIVISION DIRECTOR APPROVAL: _____
James E. Malloch

DOCUMENTATION: Included: X To Follow: ___ Not Required ___

DISPOSITION: _____ Agenda Item #: C7

MONROE COUNTY BOARD OF COUNTY COMMISSIONERS

CONTRACT SUMMARY

Contract #

Contract with: Florida Medicaid Program Effective Date: 9/1/2004

Expiration Date: Ongoing

Contract Purpose/Description: To enable Monroe County to continue in a Provider Agreement to participate in the Florida Medicaid Program for Assistive Care Services for residents of Bayshore Manor.

Contract Manager: Louis LaTorre (Name) 4572 (Ext.) Social Services (Department)

for BOCC meeting on 8/18-8/19/04 Agenda Deadline: 8/3/04

CONTRACT COSTS

Total Dollar Value of Contract: $N/A Current Year Portion: $N/A

Budgeted? Yes ☐ No ☐ Account Codes: _____-_____-_____-_____-_____

Grant: $-0- _____-_____-_____-_____-_____

County Match: $N/A _____-_____-_____-_____-_____

_____-_____-_____-_____-_____

ADDITIONAL COSTS

Estimated Ongoing Costs: $-0-/yr For: N/A

(Not included in dollar value above) (eg. maintenance, utilities, janitorial, salaries, etc.)

CONTRACT REVIEW

	Date In	Changes Needed	Reviewer	Date Out
Division Director	_____	Yes ☐ No ☑		7/30/04
Risk Management	7/28/04	Yes ☐ No ☒		7-28-04
O.M.B./Purchasing	07/28/04	Yes ☐ No ☑		7/28/04
County Attorney	7/26/04	Yes ☐ No ☑		7/26/04

Comments: _____

OMB Form Revised 9/11/95 MCP #2

INSTITUTIONAL
MEDICAID PROVIDER AGREEMENT

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

The Provider agrees to participate in the Florida Medicaid program under the following terms and conditions:

(1) Discrimination. The parties agree that the Agency for Health Care Administration (AHCA) may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with AHCA; who is performing services or supplying goods in accordance with federal, state, and local law; and who agrees that no person shall, on the grounds of sex, handicap, race, color, national origin, other insurance, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from AHCA.

(2) Quality of Service. The provider agrees that services or goods billed to the Medicaid program must be medically necessary, of a quality comparable to those furnished by the provider's peers, and within the parameters permitted by the provider's license or certification. The provider further agrees to bill only for the services performed within the specialty or specialties designated in the provider application on file with AHCA. The provider must deliver the services or goods to eligible Medicaid recipients to receive payment from AHCA.

(3) Compliance. The provider agrees to comply with local, state, and federal laws, as well as rules, regulations, and statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA.

(4) Term and signatures. The parties agree that this is a voluntary agreement between AHCA and the provider, in which the provider agrees to furnish services or goods to Medicaid recipients. Provided that all requirements for enrollment are met and remain in effect, this agreement shall remain in effect for three (3) years from the effective date of the provider's eligibility which is written in the office area below unless otherwise terminated. This agreement is renewable only by mutual consent. The provider understands and agrees that no AHCA signature is required to make this agreement valid and enforceable. This agreement shall be accepted and entered into by AHCA upon the assignment of a provider number and effective date as provided for herein.

(5) Provider Responsibilities. The Medicaid provider shall:

(a) Possess at the time of the signing of the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional, occupational, facility or other license appropriate to the services or goods provided, as required by law.

(b) Keep, maintain, and make available in a systematic and orderly manner all medical and Medicaid-related records as AHCA requires for a period of at least five (5) years.

(c) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients as required by law.

(d) Send, upon request or as required by applicable handbooks and at the provider's expense, legible copies of all Medicaid-related information to authorized state and federal employees, including their agents. The provider shall give state and federal employees, including their agents, access to all Medicaid patient records and to other information that is inseparable from Medicaid-related records.

(e) Bill other insurers and third parties, including the Medicare program, before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person.

(f) Refund within 90 days of receipt any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program.

(g) To the extent allowed by in and accordance with section 768.28, F.S. (2001), and any successor legislation, be liable for and indemnify, defend, and hold AHCA harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a recipient or a person believed to be a recipient.

(h) Accept Medicaid payment as payment in full, and not bill or collect from the recipient or the recipient's responsible party any additional amount except to the extent AHCA permits or requires, co-payments, coinsurance, or deductibles will recipients' pay for the services or goods provided. This includes situations in which the provider's Medicare coinsurance claims are denied in accordance with Medicaid's payment.

(i) Agrees to submit claims to AHCA electronically and to abide by the terms of the Electronic Claims Submission Agreement.

(j) Agrees to receive payment from AHCA by Electronic Funds Transfer (EFT). In the event that AHCA erroneously deposits funds to the provider's account, then the provider agrees that AHCA may withdraw the funds from the account.

(6) AHCA Responsibilities. AHCA:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim.

(b) Will not seek repayment from the provider in any instance in which the Medicaid overpayment is attributable solely to error in the state's determination of eligibility of a recipient.

(7) Termination For Convenience. This agreement is terminable upon thirty (30) days written notice with or without cause by either party.

(8) Ownership. The provider agrees to give AHCA sixty (60) days written notice before making any change in ownership of the entity named in the provider agreement as the provider. The provider is required to maintain and make available to AHCA Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement. Nursing facilities have the option to assign this agreement to the new provider as a result of sale, lease, or any other change in operational ownership subject to all terms and conditions under which the agreement was originally issued. In the event of a change in Hospital ownership, the new provider agrees to assume all liabilities due from previous providers to the agency, regardless of when the liabilities are identified, in order to participate in the Medicaid program.

(9) Complete Information. The provider is required to furnish true and complete statements and information to AHCA before signing the provider agreement. The provider is obligated to inform AHCA in writing of any change in the statements and information prior to the change. The filing of a materially incomplete, misleading or false application will make the application and agreement voidable at the AHCA's option and is sufficient cause immediate termination of the provider from the Medicaid program and/or revocation of the provider's number.

(10) Interpretation. When interpreting this agreement, it shall be neither construed against either party nor considered which party prepared the agreement.

(11) Governing Law. The parties consent to governance by and interpretation of their agreement in accordance with the State of Florida's laws.

(12) Amendment. This agreement, application and supporting documents constitute the full and entire agreement and understanding between the parties with respect to their relationship. No amendment is effective unless it is in writing and signed by each party.

(13) Severability. If one or more of the provisions contained in this agreement or application are declared invalid, then the other provisions remain valid.

(14) Agreement Retention. The parties agree that AHCA may only retain the signature page of this agreement, and that a copy of this standard provider agreement is maintained by the Director of Medicaid, or his designee, and reproduced as a duplicate original for any purpose and usable as evidence in any legal proceeding.

(15) Funding. This contract is contingent upon the availability of funds.

(16) Assignability. The parties agree that neither may assign their rights under this agreement without the express written consent of the other.

THE SIGNATORIES REPRESENT THAT THEY HAVE READ THE AGREEMENT, UNDERSTAND IT, AND ARE AUTHORIZED TO EXECUTE IT ON BEHALF OF THEIR RESPECTIVE PRINCIPALS.

FOR OFFICE USE ONLY

The Provider entity name is: **__Monroe County Bd Of County Commissioners__**

The facility's d/b/a name is: **___Bayshore Manor ____**

The provider number is: **_____1401599 00_____**

The effective date of this agreement is: **_____September 1, 2004_____**

The termination date is: **____August 31, 2007_____**
(dates and numbers are added upon completion of enrollment)

IN WITNESS WHEREOF, the undersigned representative of the above executed this agreement under the penalty of perjury and now affirms that the foregoing is true and correct.

Signature and Title of Provider's Authorized Representative Date

(You must legibly print or type the above signature and title.)

_____59-6000749_____

{You must legibly print or type your Federal Employer Identification Number (FEIN).}

APPROVED AS TO FORM:
SUZANNE A. HUTTON
ASSISTANT COUNTY ATTORNEY
7/26/04